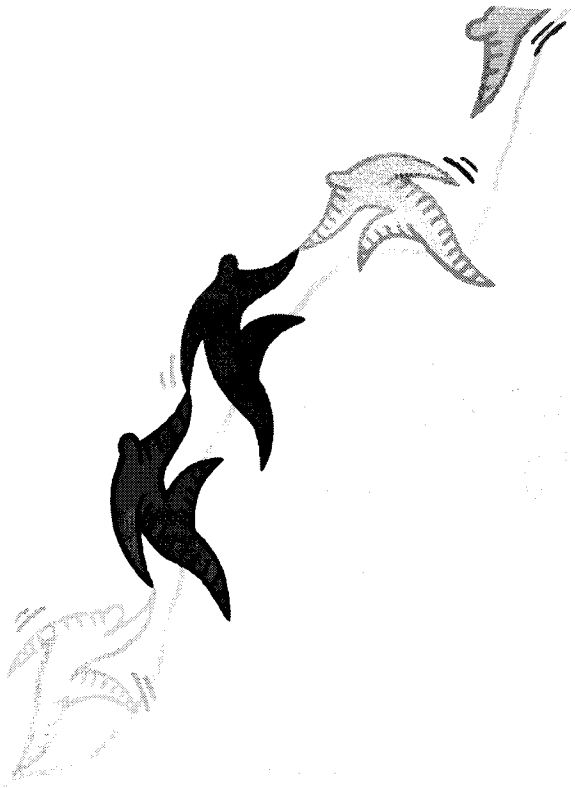
South Carolina Department of Social Services
Division of Human Services
Child Protective Services



Mission: The mission of the South Carolina Department of Social Services (SCDSS) is to ensure the safety and health of children and adults who cannot protect themselves, and to assist those in need of food assistance while transitioning into employment.

A Self Assessment of Multidisciplinary Treatment Team Building in Child Protective Services

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Child Protective Services

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Mission

The mission of the South Carolina Department of Social Services (SCDSS) is to ensure the safety and health of children and adults who cannot protect themselves, and to assist those in need of food and other assistance while transitioning into employment.

Problem Statement

The South Carolina Department of Social Services is the governmental entity mandated to provide Child Protective Services (CPS) to children and families. A task of this magnitude cannot be accomplished without supportive relationships within the community and effective partnerships with other agencies. Families do not live in isolation nor can the agency serve families in isolation.[1] This project was chosen to assess whether the implementation of statewide multidisciplinary teams (MDT) in counties who do not utilize teams, compared to counties with multidisciplinary teams, would enhance collaboration between DSS and the community stakeholders and affect a positive outcome on the safety (an environment free from abuse and neglect) and well-being (a nurturing environment in which children's physical, emotional, educational, and social needs are met) for children when the Department of Social Services intervenes with families. Keeping children safe is the paramount goal of CPS.[2] While data is collected from community stakeholders for Child Welfare Service Reviews, data to address the use and impact of multidisciplinary teams in CPS has not been collected. In the last revision to The Children's Code Reform Act of 2002, the requirement for DSS county offices to develop and participate in multidisciplinary teams was eliminated.

However, federal statute, the Child Abuse Prevention and Treatment Act (CAPTA), requires the consultation or communication between specific professionals to ensure the sharing of information, such as The Department of Juvenile Justice (DJJ) and The Department of Health and Environmental Control (DHEC). An MDT is a group of professionals who work together in a coordinated and collaborative manner to ensure an effective response to child abuse and neglect.[3] Many states define the membership of MDT in statute. The majority of teams include law enforcement, child protection, DJJ, mental health, health department, educators, alcohol and drug professionals within the community (Appendix F). Multidisciplinary team meetings provide a venue for community professionals and stakeholders to share information, to educate or train members and make recommendations regarding intervention and services. This is especially true for cases that they have in common. Without these teams, decisions regarding the family are often based solely on the judgment of the CPS staff. Decisions made without input from other individuals who may have insight into the family situation, may exclude important information necessary to provide appropriate services thereby leaving children at risk of harm. "Each community has a legal and moral obligation to promote safety, permanency, and well-being of its children."[4]

Data Collection

Eight counties defined as similar in size based on the number of child welfare direct service staff authorized for the county were selected from the Human Services Management Reports Summary (Appendix D) and a statewide survey conducted by the CPS program August 2007 identified the existence or the lack of multidisciplinary teams. Counties

with multidisciplinary teams identified the stakeholders participating on their team.

Counties similar in size are defined by the following formula:

Extra small (ES) (offices authorized for less than five (5) child welfare direct service staff)

Small (S) (offices authorized for between five (5) and nine (9) child welfare direct service staff)

Medium (M) (offices authorized for between 10-17 child welfare direct service staff)

Large (L) (office authorized for between 23-39 child welfare direct staff)

*The definitions did not address counties authorized for 18 to 22 child welfare direct service staff.

The counties included in the data collection are as follows:

Counties with MDT	Counties without MDT
Saluda (ES)	Allendale (ES)
Dillon (S)	Laurens (M)
Cherokee (M)	Lancaster (M)
Sumter (L)	Kershaw (ES)
York (L)	Bamberg (ES)

The stakeholders include, but are not limited to:

1 DSS case workers and supervisors

2 Law Enforcement

3 Department of Mental Health

4 Department of Alcohol and Other Drug Abuse Services

5 Department of Juvenile Justice

6 Department of Disabilities and Special Needs

7 Public and Private Schools and Other Educational Facilities

8 Department of Health and Environmental Control

9 Guardian Ad Litem Program

10 South Carolina Coalition Against Domestic Violence and Sexual Assault

The majority of teams involve professionals or stakeholders who collaborate to address interrelated problems rather than nonprofessionals and volunteers who seek to enhance the effectiveness of the agency services.[5]

Appendix "A" was sent to CPS staff (caseworkers, supervisors and program directors) and Appendix "B" to the stakeholders identified by county staff in counties with multidisciplinary teams. Appendix "C" was also sent to CPS staff (caseworkers, supervisors and program directors) in counties without multidisciplinary teams. The survey instrument used responses with a scale option to select the best choice ranging from to "a very little extent" to "a very great extent" and an option of "does not apply or don't know" for 23 items. Twelve open-ended questions for counties without multidisciplinary teams and four open-ended questions for counties with MDT were used to gather information on the type team, their perception of team functioning, the impact of the team on child safety and child well-being (physical and mental health and educational needs), information sharing, working together such as team decision-making, training, recommendations, and the agency's response to recommendations. Information was gathered from counties without multidisciplinary teams regarding staff's perception toward the concept of community collaboration through MDT to meet the agency's mission for child safety and child well-being.

A review of each of the ten counties' Child Welfare Services Review (CWSR) was completed to evaluate the county's performance in meeting child safety, specifically the risk of harm and the child well-being (educational, physical and mental health) measures

for Child Protective Services treatment services. As required by law, SC Code of Laws Ann., Section 43-1-115, the Department of Social Services must conduct, at least once every five years, a substantive quality review of the Child Protective Services and Foster Care programs in each county and each adoption office in the State. The report is submitted to the Governor and to each member of the County Legislative Delegation and posted on the Department's website (http://www.state.sc.us/dss/reports/files/516E.pdf). The Child Welfare Services Review (CWSR) reflects a review of records documented in the Child and Adult Protective Services System (CAPSS) and statistical information. Interviews with clients, staff and stakeholders regarding their perception of county services is also included. The findings from two independent reviews of the CPS program conducted by the South Carolina Legislative Audit Council (LAC) and the SC Citizen Review Panels (CRP) were also reviewed. Books, pamphlets and internet research on multidisciplinary teams were used to obtain additional information regarding agency collaboration.

A scale of 0 to 5 was used where the score 5 represents the highest agreement and 1 represents the lowest agreement. The score 0 was used to represent the choice, "does not apply or did not know" for 23 statements for DSS case workers, supervisors, and stakeholders.

Data Analysis:

AGREEMENT

Stakeholders

The items identified as most beneficial or relevant to stakeholders were numbers 7, 14,

15, 16, 17, 18, 21, and 22. These items suggest that the stakeholders, as members of their local multidisciplinary teams, are knowledgeable regarding agency policies and procedures that enable them to make more informed decisions and appropriate recommendations to positively impact child safety and well-being. Stakeholders report cooperativeness and satisfaction with their individual and collaborative involvement in MDT. Key elements in working as a team such as providing the opportunity for the exchange of information and mutual respect of team members were also identified.

Counties with MDT

DSS staff in counties with multidisciplinary teams report items 3, 4, 15, 17, 19, and 21 as the most relevant items. The ratings reflect that staff strongly supports use of MDT as a forum for discussing issues and sharing information for specific recommendations that impact child safety and well-being. MDT provides learning opportunities from a variety of disciplines through training and team discussions.[6] Items 15, 17 and 21 are three items shared by both groups.

Counties without MDT

Items 3, 4, 7, 9, and 14 were rated the highest overall, however, staff ratings in counties without MDT were lower than the ratings of staff with MDT. This may be attributed to smaller counties having less staff to complete the survey. Staff in counties without MDT support to a great extent that MDT will provide a forum to discuss issues, share information, and be effective in coordinating services to families. The survey reflects that they are knowledgeable about agency policies and procedures and community resources. All surveys from the counties without multidisciplinary teams reflected that

they would support having an MDT in their county. The participants who selected the rating "does not apply" or "don't know" indicated that they were recently employed or not familiar with MDT and thus were unable to give an opinion.

DISAGREEMENT

There were no areas of disagreement between stakeholders and county staff in counties with MDT and without MDT. The participants in the survey reflected that MDT would enhance collaboration between DSS and the community stakeholders and affect a positive outcome on the safety and well-being for children when the Department of Social Services intervenes with families. One worker's rating reflected that MDT would provide very little support in building a supportive relationship to impact child safety and well-being.

CWSR

The Child Welfare Services Review interviews with stakeholders reflect the following concerns:

- Parents are given too many chances to change their behavior
- DSS staff should monitor families more closely
- DSS is effective in addressing the educational needs of children
- DSS is both effective and not effective in addressing the physical health and medical needs of children according to stakeholder feedback. Stakeholders state that DSS is not effective when children who are at risk are not removed.
- DSS staff is well prepared in court and have good coordination between caseworkers and Guardians Ad Litem (GAL)
- DSS staff don't have enough time

- There is not enough funding
- Joint training for the school and other agencies is needed
- DSS sometimes appears unresponsive, especially at the end of the day for educational neglect cases
- Communication of the policies and procedures for referrals is needed
- The roles of the agencies need to be more clearly defined
- The system could be improved

BARRIERS

Common barriers for MDT identified by participants in the survey included lack of time, resources and support as well as DSS' failure to follow up on recommendations or to provide updates.

LAC REPORTS NONCOMPLIANCE

A total of five counties were reviewed by LAC in 2006. Two of these counties, Kershaw and York, participated in the survey. Most significant in the report was that CPS was critically understaffed; the agency violated State law and DSS policy in certain areas of CPS responsibility, and information in Child and Adult Protective Services System (CAPSS), the agency's automated information system for child welfare to record case actions, was identified as "not entirely reliable".[7]

The LAC report did not address stakeholders' concerns or consider collaboration with agency providers or stakeholders.

Summary of CWSR Ratings for Counties Participating in MDT Survey

The following is a listing of ratings/outcomes identified through the CWSR process for

the counties participating in the survey. "ANI" means the item was identified as an "area needing improvement" and "S" means the item was identified as a "Strength.

	MDT	Without MDT
Risk of harm	4 (ANI) and 1 (S)	3 (ANI)/2 (S)
Education	4 (ANI)/1 (S)	4 (ANI)/1 (S)
Physical Health	4 (ANI)/1 (S)	3 (ANI)/2 (S)
Mental Health	4 (ANI)/1 (S)	3 (ANI)/2 (S)

The process used to arrive at the rating is based on case documentation found in the records during the review. The CWSR for counties with and without MDT reflect that the counties without MDT met one additional strength for safety (risk of harm) and physical and mental health. On the surface it appears that counties without MDT may provide better services to meet child safety and well-being for children. This finding indicates that further research is needed to determine the key factors that contribute to the ability of smaller counties without multidisciplinary teams to meet additional safety and well-being outcomes than counties with multidisciplinary teams.

Some of the possibilities include the fact that counties without MDT are small and the communities are more cohesive than slightly larger counties. Stakeholders and service providers may attend the same church, school, and shop at the same store thus allowing more opportunity for interactions. Also a smaller population may contribute to workers having smaller caseloads which allow additional time for making contact. These informal relationships operate in the same way as having a multidisciplinary team and appear to provide the same benefits. It should be noted that the above findings do not

negate the benefits of having an MDT.

Counties with MDT responded that they have standing teams that meet regularly or as needed with the county. Some stakeholders, such as medical providers, served on several teams. All stakeholders were professionals in the community. The stakeholders and DSS staff have varying degrees of employment experience. The teams focused primarily on investigative cases, however, some teams also reviewed and staffed treatment cases. The overwhelming majority of respondents were female (54). Five (5) males participated in the survey. This may not have any significance to the outcomes but is included for demographic information.

Implementation Plan:

SCDSS had originally planned to utilize technical assistance from the National Resource Center (NRC) on Child Protective Services to increase the agency's capacity to assist county staff in organizing and maintaining multidisciplinary teams. The agency uses the NRC in a variety of ways to improve the practice and increase capacity of the agency to support best practice in the field. Given the findings from the survey and an analysis of information used to complete the project, it appears premature to proceed to request technical assistance for federal FY 08-09 to include this area. Instead, DSS should consider conducting more comprehensive research into the pros and cons of multidisciplinary teams.

Summary and Recommendations

"Caseworkers are not service dispatchers. Rather, they are agents of change who can help promote positive outcomes for children and families. Building helping community relationships can significantly improve people's lives through collaboration among

service providers and community institutions."[8]

Outcome data from the federal Child and Family Services Review supports that use of a multidisciplinary team to staff cases for decisions and for service delivery is a valid method to improve outcomes for children and families. This survey suggests that it is not the only method to improve outcomes for children and families. Due to the difficulty I gathering data from front line staff, who did not always respond to the questionnaire, it is difficult to draw valid conclusions from the data collected and I acknowledge that the data may not be totally reliable. Although the Child Welfare Services Reviews in South Carolina did not show absolute correlation between improved outcomes in counties with MDT, we see that agency partners and stakeholders agree that involvement in case staffings provides an opportunity for enhanced communication and better delivery of services that are based on the needs identified. The federal office of the Administration of Children and Families (ACF) encourages states to implement multidisciplinary teams to increase communication and enhance coordination of services. SCDSS has for many years encouraged counties to convene and maintain multidisciplinary teams to ensure comprehensive sharing of information so as to make the most informed decisions and to have sufficient input to support delivery of appropriate services. The MDT also has the benefit of identifying gaps in services as well as inadequate resources within a community and can provide the opportunity to develop resources to close the gap. In the absence of specific statutory requirements, some counties have continued to maintain their multidisciplinary teams through personal relationships. CPS should focus on conducting more comprehensive research to identify factors that will have the greatest impact on achieving safety and well-being and to determine if other strategies will lead to better outcomes for children and families, and

under what circumstances. An example of community networking efforts is Project Best, a mental health treatment initiative for abused or neglected children that supports the use of multidisciplinary teams to evaluate the needs of children and develop plans for treatment. The project involves increasing the capacity of communities to deliver evidence supported mental health treatment and involves the Children's Advocacy Centers and other stakeholders to help build community capacity. Decisions that have life or death consequences should be shared and not made unilaterally. Teams are necessary to coordinate efforts of multiple agencies to promote understanding and help make these decisions."

Evaluation Method:

DSS Technical Assistance Staff provide consultation and evaluation of the CPS program through review of records and regular visits to county offices. These staff members can help counties focus on community collaboration as part of their CWSR Program Improvement Plan and will continue to include and focus on community stakeholders. LAC will conduct a second review in February 2008 to evaluate progress made by the CPS program. These combined reports, in addition to State Office's monitoring of the CPS program, should give an indication of the effectiveness and benefit of MDT to counties who use them. Further research should be conducted by program to determine which factors have the greatest impact on achieving desired state outcomes. This research should include a preliminary community analysis of counties with and without multidisciplinary teams to determine the format to best obtain and share information. To support CPS outcomes of safety and child well-being the possible use of Memorandums of Agreement with other agencies and the possible inclusion of non-traditional service

providers should be considered. In addition, CPS can conduct public forums and regional meetings to hold informal discussions in counties that have been successful meeting safety and well-being outcomes and develop ways to share the strategies used.

Footnotes

[1] DePanfalis, Diane and Salus, Marsha K.; Child Protective Services: A Guide for Caseworkers Child Abuse and Neglect User Manual Services, US Department of Health and Human Services, 2003

[2] Jenkins, James L.; MacDicken, Robert A.; and Ormsby, Nancy J.; A Community Approach: The Child Protection Coordinating Committee, National Center on Child Abuse and Neglect, Children's Bureau; Administration for Children, Youth and Families, Office of Human Development Services, Washington, DC 1979

[3] Ells, Mark; Forming a Multidisciplinary Team to Investigate Child Abuse. US Department of Justice, Washington, DC (1998)

[4] Goldman, Jill; Salus, Marsha K.; Wolcott, Deborah; and Kennedy, Kristie Y.; A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice, US Department of Health and Human Services, Washington, DC 2003

[5] Robertson, Duncan; Reform Agenda Fact Sheet 7, What is an integrated, comprehensive and multidisciplinary team? http://medicinejrank.org/pages1191/Multidisciplinary-Team.html

[6] Parker, Glenn M.; Cross-functional Teams Working with Allies, Enemies, and other Strangers. John Wiley and Sons, 2003

[7] A Review of the Child Protective Services Program at the Department of Social Services 2006, www.lac.sc.gov/Reports2006CPS.htm

[8] Morton, Thomas D. and Holder, Wayne; Issues and Strategies for Assessment Approaches to Child Maltreatment. National Resource Center on Child Maltreatment (NRCCM), Washington, DC, 2000

Appendix A
Survey Total for Counties With Multidisciplinary Treatment Teams (Staff)

South Carolina Department of Social Services Child Protective Services Multidisciplinary Treatment Team Questionnaire for Counties With MDT (Total)							
Indicate with an X the response which best represents your opinion for the following statements about your multidisciplinary treatment team (MDT)							
Statement	To a very little extent	To a little extent	To some extent	To a great extent	To a very great extent	Does not apply or don't know	No Response
1. MDT helps build supportive relationships with community organizations	0	1	9	20	10	8	0
2. MDT meetings are held in a timely manner so that input from all stakeholders is received	1	2	9	24	3	9	0
3. MDT provides a forum to discuss issues relevant to the case	0	0	8	20	13	7	0
4. MDT provides a forum to share information about cases	1	0	8	21	11	7	0
5. When MDT meetings are held, members are able to attend	0	2	10	18	8	10	0
6. Team members are knowledgeable about issues of child abuse and neglect	1	2	16	17	5	7	0

Appendix A cont'd

South Carolina Department of Social Services
Child Protective Services
Multidisciplinary Treatment Team Questionnaire for Counties With MDT (Total)

Indicate with an X the response which best represents your opinion for the following statements about your multidisciplinary treatment team (MDT)

Statement	To a very little extent	To a little extent	To some extent	To a great extent	To a very great extent	Does not apply or don't know	No Response
7. Team members are knowledgeable about their agency policies and procedures	0	1	16	14	9	8	0
8. Team members are provided information regarding changes in statute and policy	4	1	21	9	5	8	0
9. Team members are knowledgeable about community resources in their area of expertise	1	0	16	13	9	9	0
10. Information shared with team members is sufficient to make recommendations	0	1	13	17	8	8	1
11. MDT promotes teamwork to improve responses to child abuse	2	4	11	15	8	8	0
12. MDT is beneficial to CPS staff	1	2	13	10	14	7	1
13. MDT is beneficial to me	0	2	16	11	9	9	1

Appendix A cont'd

South Carolina Department of Social Services Child Protective Services Multidisciplinary Treatment Team Questionnaire for Counties With MDT (Total)							
Indicate with an X the response which best represents your opinion for the following statements about your multidisciplinary treatment team (MDT)							
Statement	To a very little extent	To a little extent	To some extent	To a great extent	To a very great extent	Does not apply or don't know	No Response
14. MDT is effective in coordinating services to families	1	2	15	13	8	9	0
15. Recommendations focus on child safety	0	2	10	17	10	9	0
16. Recommendations Focus on child well-being (i.e. physical/mental health, education)	0	2	8	20	9	9	0
17. Recommendations Are individualized for each individual/family	2	1	11	16	8	10	0
18. Recommendations are appropriate for the family members	1	2	17	13	5	9	1
19. Team members Agree upon recommendations made	0	1	14	22	2	9	0
20. Recommendations Made on cases are followed	0	0	16	15	7	10	0
21. Recommendations actually impact child safety	0	0	13	18	8	9	0
22. Recommendations Impact child well-being	0	1	10	21	7	8	1
23. Training is provided To MDT members	5	6	13	6	1	16	1

Appendix A cont'd

24. What are the strengths of your local MDT?
The information received; small town communication is easier, open and honest, get along; people from other agencies are knowledgeable about the resources and services, members collaborate effectively; common meeting place where all agencies come together and don't have to travel far; communication between the different agencies; brings members together and all are on the same page, opportunity to share background information in a timely fashion

25. What are the barriers? (i.e. confidentiality) Conflicting views on recommendations and preconceived views by different agencies, attendance, time everyone is busy, agencies are only interested in what they are mandated to do, not held very often, lack of local resources and client has to travel outside community to receive services which is a hardship for the agency and client, none

26. How satisfied are you with your MDT? Scale of 1 to 10 I give it a 6, takes workers away from their work, no one showed up, very satisfied, most are satisfied

27. What changes can be made to improve your MDT? Focus on child safety and well being and less on agencies; get started again with more agencies and medical professionals involved, meet on a regular basis, be more diligent about attending; individual services need to be outlined and maybe an interagency training could be held to help new employees to be more aware of the extent of services each specific agency provides to enable one to direct more appropriately; desired interest of each case presented; more scheduled dates; needs statewide overhaul; sharing information more rapidly

APPENDIX A – cont'd

The following information is necessary to analyze the data from the survey. This information is confidential and will be used only to categorize your response. Please circle or fill in your response.

1. Which best describes your position/role?

   Caseworker (34) Supervisor (12) Stakeholder
   No response (2)

2. How long have you been employed in your position?

   Employment ranged from 3 months to 30 years

3. How often does your MDT meet?
   Monthly

4. In which county do you participate in MDT?
   Within the respective county

5. What is your gender? Male (4) Female (38)
   No response (3)

6. What is your ethnic origin?
   Caucasian (17); African American (22); Hispanic (0); Native American (0);
   Bi-Racial (1); Other
   No Response (1)

Your cooperation in completing this questionnaire is very much appreciated. Thank you.

If you have any questions, please contact me at (803) 898-7810. Please return the questionnaire to my email address: Pamela.Rice@dss.sc.gov

Appendix B

Survey Total for Counties With Multidisciplinary Treatment Teams (Stakeholders)

South Carolina Department of Social Services
Child Protective Services
Multidisciplinary Treatment Team Questionnaire for Stakeholders (Total)

Indicate with an X the response which best represents your opinion for the following statements about your multidisciplinary treatment team (MDT)

Statement	To a very little extent	To a little extent	To some extent	To a great extent	To a very great extent	Does not apply or don't know	No Response
1. MDT helps build supportive relationships with community organizations	0	0	0	3	7	2	0
2. MDT meetings are held in a timely manner so that input from all stakeholders is received	0	0	0	6	4	2	0
3. MDT provides a forum to discuss issues relevant to the case	0	0	0	6	4	2	0
4. MDT provides a forum to share information about cases	0	0	0	4	6	2	0
5. When MDT meetings are held, members are able to attend	0	1	0	5	4	2	0

APPENDIX B – cont'd

South Carolina Department of Social Services Child Protective Services Multidisciplinary Treatment Team Questionnaire for Stakeholders (Total)							
Indicate with an X the response which best represents your opinion for the following statements about your multidisciplinary treatment team (MDT)							
Statement	To a very little extent	To a little extent	To some extent	To a great extent	To a very great extent	Does not apply or don't know	No Response
6. Team members are knowledgeable about issues of child abuse and neglect	0	0	1	8	2	1	0
7. Team members are provided information regarding changes in statute and policy	0	0	0	6	5	1	0
8. Team members are provided information regarding changes in statute and policy	0	0	3	5	2	2	0
9. Team members are knowledgeable about community resources in their area of expertise	0	0	1	5	5	1	0
10. Information shared with team members is sufficient to make recommendations	0	0	1	4	5	1	1
11. MDT promotes teamwork to improve responses to child abuse	0	0	0	4	6	2	0

APPENDIX B – cont'd

South Carolina Department of Social Services Child Protective Services Multidisciplinary Treatment Team Questionnaire for Stakeholders (Total) Indicate with an X the response which best represents your opinion for the following statements about your multidisciplinary treatment team (MDT)							
12. MDT is beneficial to CPS staff	0	0	0	5	4	3	0
13. MDT is beneficial to me	0	0	0	6	4	2	0
14. MDT is effective in coordinating services to families	0	0	0	4	7	1	0
15. Recommendations focus on child safety	0	0	0	3	8	1	0
16. Recommendations Focus on child well-being (i.e. physical/mental health, education)	0	0	0	4	7	1	0
17. Recommendations are individualized for each individual/family	0	0	0	6	5	1	0
18. Recommendations are appropriate for the family members	0	0	0	6	5	1	0
19. Team members agree upon recommendations made	0	0	1	7	3	1	0
20. Recommendations made on cases are followed	0	0	0	5	3	4	0
21. Recommendations actually impact child safety	0	0	0	5	6	1	0
22. Recommendations impact child well-being	0	0	0	5	6	1	0
23. Training is provided to MDT members	1	1	4	1	0	5	0

APPENDIX B – cont'd

28. What are the strengths of your local MDT?
The information received; overall, the team works well together in order to do what is best for the children, as well as their families; each member brings their skills and expertise to the table; we have a good sampling of community agency and leaders; that we all work together to assist families in getting the services they need; everyone works well together, and I feel I can call any of them with questions; don't know; good agencies that cooperate.

29. What are the barriers? (i.e. confidentiality) Timing and follow through: Lately, a DSS staff member appears not be as cooperative—which makes it difficult to report a suspected neglect/abuse case which our agency is required by law to do; I feel that some children fall through the cracks and do not receive the support that they should and the follow-up care; not sure at this time; we have had very little involvement with DSS; I am not sure of the purpose for the continued use of the other provider; the staff have been invited to two MDT's - this being only in the past three months; not enough resources to assist; need additional training.

30. How satisfied are you with your MDT? Most indicated that they are satisfied with their MDT, somewhat; pretty much; very satisfied; even though I am not able to attend the meetings, I still receive the minutes of the meetings; this is very beneficial when I am working with these students on a daily basis within the school setting; it is also helpful to see the outcome of the reports that we have made and to be aware of what impact this may have on a student; good group and very active team; we all do a wonderful job brainstorming so that we may assist families; don't know

31. What changes can be made to improve your MDT? Know safety issues are not always addressed.; that everyone respect the purpose and intent of MDT; I have not attended enough meetings to offer any suggestions; bring in speakers to discuss other possible services that could be available; educate team members on new laws and legislation; if the cases being staffed could be sent in a timely fashion (mailed or emailed); nothing at this time; don't know; additional training.

APPENDIX B – cont'd

The following information is necessary to analyze the data from the survey. This information is confidential and will be used only to categorize your response. Please circle or fill in your response.

7. Which best describes your position/role?

   Caseworker (2) Supervisor (1) Stakeholder (4)
   Clerk to County Council; Forensic Interviewer; Medical Examiner

8. How long have you been employed in your position?
   Employment ranged from 7 months to 26 years; most had at least 2 years experience

9. How often does your MDT meet?
   The majority responded that the team meets monthly; one response indicated that the team has not met often in the last two years

10. In which county do you participate in MDT? Within the respective county

5. What is your gender? Male (2) Female (9)

11. What is your ethnic origin? Caucasian (8); African American (5); Hispanic; Native American; Bi-Racial; Other

Your cooperation in completing this questionnaire is very much appreciated. Thank you.

If you have any questions, please contact me at (803) 898-7810. Please return the questionnaire to my email address: Pamela.Rice@dss.sc.gov

Note: One respondent survey could not be read.

APPENDIX C

South Carolina Department of Social Services
Child Protective Services
Multidisciplinary Treatment Team Questionnaire for Counties Without MDT (Total)

Indicate with an X the response which best represents your opinion for the following statements about your multidisciplinary treatment team (MDT)

Statement	To a very little extent	To a little extent	To some extent	To a great extent	To a very great extent	Does not apply or don't know	No Response
1. MDT helps build supportive relationships with community organizations	1	0	13	14	8	3	0
2. MDT meetings are held in a timely manner so that input from all stakeholders is received	0	0	10	15	11	3	0
3. MDT provides a forum to discuss issues relevant to the case	1	0	8	14	14	2	0
4. MDT provides a forum to share information about cases	1	0	6	17	14	1	0
5. When MDT meetings are held, members are able to attend	0	1	11	17	7	3	0
6. Team members are knowledgeable about issues of child abuse and neglect	1	3	7	16	11	**1**	**0**

APPENDIX C – cont'd

South Carolina Department of Social Services
Child Protective Services
Multidisciplinary Treatment Team Questionnaire for Counties Without MDT (Total)

Indicate with an X the response which best represents your opinion for the following statements about your multidisciplinary treatment team (MDT)

Statement	To a very little extent	To a little extent	To some extent	To a great extent	To a very great extent	Does not apply or don't know	No Response
7. Team members are knowledgeable about their agency policies and procedures	1	0	3	23	11	1	0
8. Team members are provided information regarding changes in statute and policy	1	2	7	14	11	2	2
9. Team members are knowledgeable about community resources in their area of expertise	1	0	5	19	10	2	2
10. Information shared with team members is sufficient to make recommendations	0	2	13	9	9	0	6
11. MDT promotes teamwork to improve responses to child abuse	1	0	11	12	10	3	2
12. MDT is beneficial to CPS staff	1	0	10	14	11	1	2
13. MDT is beneficial to me	0	2	11	11	9	4	2

APPENDIX C – cont'd

South Carolina Department of Social Services
Child Protective Services
Multidisciplinary Treatment Team Questionnaire for Counties Without MDT (Total)

Indicate with an X the response which best represents your opinion for the following statements about your multidisciplinary treatment team (MDT)

Statement	To a very little extent	To a little extent	To some extent	To a great extent	To a very great extent	Does not apply or don't know	No Response
14. MDT is effective in coordinating services to families	1	0	8	14	12	2	2
15. Recommendations focus on child safety	0	0	9	15	10	3	2
16. Recommendations Focus on child well-being (i.e. physical/mental health. education)	0	0	9	15	11	2	2
17. Recommendations Are individualized for each individual/family	0	1	8	15	11	2	2
18. Recommendations are appropriate for the family members	1	0	10	14	10	2	2
19. Team members Agree upon recommendations made	0	3	13	11	8	2	2
20. Recommendations Made on cases are followed	1	3	12	10	9	2	2
21. Recommendations actually impact child safety	1	1	11	12	9	1	4
22. Recommendations Impact child well-being	1	1	12	10	10	1	4
23. Training is provided To MDT members	3	3	10	10	7	2	4

APPENDIX C – cont'd

Do you participate on another team meeting that functions similar to a multidisciplinary team? Two counties participate in other staffings with MTS, DJJ and Counseling Services and Mental Health.

If no, what action does the DSS take to resolve difficult cases which involve other agencies? Cases are staffed with a representative of the agency or service provider involved.

If yes: How long has the team been in place?
NA

How often does the team meet?
NA

How many times has the team met this year?
NA

When was the last meeting?
NA

Is it a standing team (meet at a regular determined time) or are meetings held on an as-needed basis?
Three counties indicated that a staffing with other stakeholders is held on an as-needed basis, once a month or several times a year.

Who convenes the meeting? Different providers as well as DSS may convene the meeting such as Emergency Preparedness, Family Resource Center.

Does DSS present cases?
NA

What types of cases does DSS staff (assessment, treatment)?
Both, assessment and treatment cases including foster care are staffed.

Do you feel stakeholders in your community would support a multidisciplinary team?
If not, why? Each response was "Yes".

What would be a barrier to implementing a multidisciplinary team? (i.e. confidentiality)
Confidentiality; lack of cooperation from agencies such as law enforcement; time; attendance and the lack of knowledge of agency policies.

APPENDIX C – cont'd

The following information is necessary to analyze the data from the survey. This information is confidential and will be used only to categorize your response. Please circle or fill in your response.

1. Which best describes your position/role?
   The majority of respondents were caseworkers.

2. How long have you been employed in your position?
   10 months to 15 years

3. How often does your MDT meet?
   NA
4. In which county do you participate in MDT
   NA

5. What is your gender?
   The majority of respondents were female.

6. What is your ethnic origin?
   The majority of respondents were African American followed by Caucasian. Several failed to respond to this item or stated "not applicable."

Your cooperation in completing this questionnaire is very much appreciated. Thank you.

If you have questions, please email or contact me at (803) 898-7810. Please email the questionnaire to: Pamela.Rice@dss.sc.gov

Appendix D

Human Services Management Reports Summary
January 2006 – CAPSS Data Report

The summaries of CAPSS DATA Reports include the major program areas to include Child Protective Services, Foster Care and Adult Services. Information was listed based on county size and distributed statewide by the Division of Planning & Quality Assurance. County sizes were listed as below:

Extra small (ES) (offices authorized for less than five (5) child welfare direct service staff)

Small (S) (offices authorized for between five (5) and nine (9) child welfare direct service staff)

Medium (M) (offices authorized for between 10-17 child welfare direct service staff)

Large (L) (office authorized for between 23-39 child welfare direct staff)

*The definitions did not address counties authorized for 18 to 22 child welfare direct service staff.

Child Protective Services (CPS) reports focused on the following:

1. CPS Investigations: The total number of CPS investigations, determinations or case decisions not completed within 45 days, and intakes over 4 months with no case decision.

2. CPS Treatment: This was a new report designed to show worker activity in all the CPS treatment cases. It included the number of children receiving CPS services and identified the number of open treatment cases within a county that had no case actions or activities documented or entered into CAPSS in the last three months. The report also identified the total open treatment cases, the total children in the treatment cases, cases that were open without any children identified (attached), and the average number of months the treatment cases remained open.

APPENDIX E

Human Services Quality Reviews by County
County Child Welfare Service Reviews

Child Welfare Services Review Summary (*denotes counties with MDT)

County Date	Risk of Harm Rating	Educational Rating	Physical Health Rating	Mental Health Ratings
Allendale 2/2006	ANI	ANI	ANI	ANI
Bamberg 4/2005	S	S	S	S
*Cherokee 1/2005	ANI	ANI	ANI	ANI
*Dillon 1/2007	S	ANI	ANI	ANI
Kershaw 1/2005	S	ANI	ANI	ANI
Lancaster 12/2006	ANI	ANI	S	S
Laurens 10/2005	ANI	ANI	ANI	ANI
*Saluda 6/2006	ANI	ANI	ANI	ANI
*Sumter 1/2006	ANI	ANI	S	S
*York	ANI	S	ANI	ANI

The full Quality Assurance Child Welfare Services Review for the state can be found on the agency's website at http://www.state.sc.us/dss/reports/files/516E.pdf

APPENDIX E
Child Welfare Services Review Stakeholder Summary

Child Welfare Services Review Stakeholders Summary for outcomes on Safety and Well Being:

Risk: Inadequate response by DSS to risk factors clearly identified and documented such as noncompliance by parents; staff are well informed in identifying risk factors and try to prevent recurrence; believe DSS reduces risk of harm; cases involving drug addicted parents were reported to DSS numerous times before children were removed; sporadic contact or no home visits;

Educational: Failure to follow up on identified educational needs; lack of documentation that children's needs were assessed; not all children in the home were assessed; no documentation that educational issues were addressed in supervisory staffing; school records were in case file.

Physical Health: Significant lapses in services; medical reports are not filed; lack of documentation that children's needs were assessed; not all children in the home were assessed; no effort to follow up to determine if medical needs were met.

Mental Health: Not all family members were being adequately addressed by service providers; effective in identifying and addressing emotional needs of children; no documentation to support the child's mental health needs were being addressed.

APPENDIX E Cont'd

The 2005-2006 ANNUAL PROGRESS AND SERVICES REPORT for the SOUTH CAROLINA TITLE IV-B FIVE-YEAR STATE PLAN FOR CHILD WELFARE SERVICES FISCAL YEAR

The 2005-2006 ANNUAL PROGRESS AND SERVICES REPORT for the SOUTH CAROLINA TITLE IV-B FIVE-YEAR STATE PLAN FOR CHILD WELFARE SERVICES FISCAL YEAR 2005-2006 found on the agency's website (http://www.state.sc.us/dss/reports/files/516E.pdf) contains Section VII. Child Abuse Prevention Treatment Act (CAPTA) that mandates the creation and improvement of the use of multidisciplinary teams and the development of interagency protocols to enhance investigation and directs the sharing of information between DSS and Law Enforcement by developing protocols Section VIII addresses "The Citizens Review Panels 2006 Annual Report and Agency Response." The Citizen Review Panels (CRP) addressed policy and procedure, practice and community impact.

Recommendations include placing the manual on the Internet and sharing the outcome or the status of child abuse and neglect reports with the reporter. Currently, DSS has its manuals located on its Internet system – Lotus Notes, and statute provides for sharing the outcome of the report with the reporter, however, this information is limited to whether the agency will or will not provide services.

APPENDIX E Cont'd

Legislative Audit Council Report to the General Assembly

Legislative Audit Council Report to the General Assembly; A Review of the Child Protective Services Program at the Department of Social Services, August 2006, found compliance issues.

The review focused on DSS' compliance with laws and policies, staffing levels, process for investigating and disciplining employees.

- DSS violated policy to make face to face visits with child and family
- Individuals wee not always entered into Central Registry for sexual abuse as required by law
- Based on the caseload for 2005, DSS needs additional staff
- Violations of law and policy for failure to terminate
- Attempts to improve performance did not work

The report in its entirety can be located on the Legislative Audit Council website at www.lac.sc.gov/Reports/2006 .The report can be found at www.state.sc.us/sclac under reports for 2006.

Appendix F

Other Relative Reports
Summary of DSS Survey of Counties (8/31/07)

MDT Report for Counties
Question asked of all County Directors on August 31, 2007:
Does your county have an MDT? If so, who is on it and who is the contact person?

COUNTY	County has an MDT	No response from county
1. ABBEVILLE	YES	X
2. AIKEN	NO	
3. ALLENDALE	NO	
4. ANDERSON		X
5. BAMBERG	YES	
6. BARNWELL	NO	
7. BEAUFORT		X
8. BERKELEY	YES	
9. CALHOUN		X
10. CHARLESTON		X
11. CHEROKEE	YES	
12. CHESTER		X
13. CHESTERFIELD		X
14. CLARENDON		X
15. COLLETON		X
16. DARLINGTON		X
17. DILLON	YES	
18. DORCHESTER	YES	
19. EDGEFIELD	YES	
20. FAIRFIELD		X
21. FLORENCE		X
22. GEORGETOWN		X
23. GREENVILLE		X
24. GREENWOOD		X
25. HAMPTON	YES	
26. HORRY		X
27. JASPER	YES	
28. KERSHAW	YES	
29. LANCASTER		X
30. LAURENS	NO	
31. LEE	YES	
32. LEXINGTON		X
33. MCCORMICK	NO	
34. MARION		X
35. MARLBORO	YES	
36. NEWBERRY	YES	
37. OCONEE		X
38. ORANGEBURG	YES	
39. PICKENS		X
40. RICHLAND	YES	
41. SALUDA	YES	
42. SPARTANBURG	YES	
43. SUMTER	YES	
44. UNION		X
45. WILLIAMSBURG		X
46. YORK		X

APPENDIX F cont'd

MULTIDISCIPLINARY TEAM MEMBERS BY COUNTY

LE/PP	MH	A&D	DJJ	SCH	DDSN	CAC	ATTY/ PP	VIC	FAM	DV	CA	GAL	DHEC	COUNTY
X	X	X	X				X	X	X					AIKEN
														BERKELEY
														CHEROKEE
	X	X		X	X	X	X		X	X	X	X		DILLON
														DORCHESTER
X			X	X									X	EDGEFIELD
X	X			X								X	X	SALUDA
X	X		X					X	X					HAMPTON
														JASPER
							X					X		KERSHAW
X	X	X	X	X	X							X	X	LEE
	X	X	X	X						X				MARLBORO
X	X	X	X	X										NEWBERRY
X				X									X	ORANGEBURG
X							X							RICHLAND
														SALUDA
														SPARTANBURG
X	X			X									X	SUMTER

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[2] Jenkins, James L.; MacDicken, Robert A.; and Ormsby, Nancy J.; A Community Approach: The Child Protection Coordinating Committee, National Center on Child Abuse and Neglect, Children's Bureau; Administration for Children, Youth and Families, Office of Human Development Services, Washington, DC 1979

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[4] Goldman, Jill; Salus, Marsha K.; Wolcott, Deborah; and Kennedy, Kristie Y.; A Coordinated Response to Child Abuse and Neglect: The Foundation for Practice, US Department of Health and Human Services, Washington, DC 2003

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